

ETHIOPIA AND HIV/AIDS

Key Talking Points

One of the poorest and the most populated countries in the world, Ethiopia is also one of the sub-Saharan African countries hardest-hit by the HIV/AIDS epidemic:

- More than 2.6 million Ethiopians are living with HIV—1.1 million with AIDS.
- In urban areas, more than one in six adults (18 percent of the population) are infected with HIV.
- The Ministry of Health predicts that the number of people living with HIV/AIDS (PLWHA) will increase to 3.2 million by 2006, and to 4.7 million by 2014.

AIDS Deaths The number of AIDS deaths will increase from about 350,000 in 1998 to 740,000 by the year 2000, and to six million by 2014. As a result of HIV/AIDS, average life expectancy will drop by 12 percent during the 1990s and stand at 47 years by 2025.

Women and HIV/AIDS In 1997, 18 percent of pregnant women in Addis Ababa antenatal clinics tested positive for HIV.

Youth and HIV/AIDS By 2014 AIDS will more than double the annual number of deaths among young adults—from 230,000 to 525,000.

Children and HIV/AIDS AIDS will increase Ethiopia's infant mortality rate by 7 percent from 1995 to the year 2000, and will become the major cause of death for children under age 5. To date, an estimated 840,000 children have been orphaned because of HIV/AIDS. By 2009 there will be more than 1.8 million AIDS orphans.

Health Care Costs Currently, only 3 percent of the central government expenditure is allocated to health.

Socioeconomic Impact About 90 percent of reported AIDS cases are 20 to 49 years old. Since this age group constitutes the most economically productive segment of the population, an enormous economic burden is created.

USAID was the largest supporter of HIV/AIDS programs in Ethiopia, contributing \$5.125 million in FY 1998. USAID support has led to one of sub-Saharan Africa's most successful social marketing programs for condoms. Five years ago condoms were largely unavailable in Ethiopia. Starting in 1996, 24 million condoms were socially marketed annually, and it is estimated that over 36 million condoms were sold in 1998.

National Response The Ethiopian government responded quickly to the epidemic, forming the National Task Force on the Prevention and Control of HIV/AIDS in 1985, one year before the country's first AIDS case was diagnosed. In 1998 the government adopted a National Policy on HIV/AIDS and is currently developing a National Strategic Plan. These are important steps forward, but the government must maintain its momentum in containing the HIV/AIDS epidemic through ongoing, strong top-level support.



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Country Profile

With a population of close to 58 million and a per capita income of only \$120 per year, Ethiopia is among both the poorest and the most populated countries in the world. Over the past year, events in the Greater Horn of Africa and the Great Lakes have served to reinforce Ethiopia's status as a critical player and an important U.S. ally in developing stability and self-reliance in a region still plagued by natural and man-made crises. The Ethiopian government, particularly its top leadership, plays an increasingly active and influential role among the new leaders emerging in Africa, the Organization for Africa Unity (OAU), and the more regionally-focused Intergovernmental Authority for Development (IGAD). Recent visits by the U.S. Secretary of State and senior Congressional figures clearly signify the importance of Ethiopia to U.S. foreign policy interests in Africa.

The Ethio-Eritrean border conflict, which began in May 1998 and escalated in February 1999, continues to weaken Ethiopia's economy and social system and has displaced as many as 275,000 Ethiopians. Drought and massive floods in 1997 and 1998 led to crop failure affecting 1.5 million people.

At the current annual growth rate of over 3 percent, Ethiopia's population could exceed 145

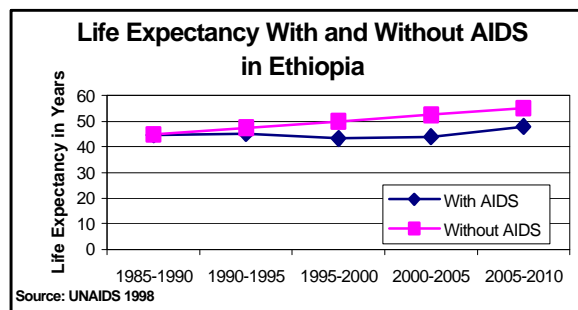
million by 2025, causing an even greater burden on basic social and medical services. The country's social statistics are still among the world's lowest, and in some cases, such as malnutrition rates and primary school enrollment, Ethiopia ranks lowest in the world. Under-financing of the health care system and poor management capacity contribute to a lack of access to basic health services and, ultimately, dismal health status. Fewer than 20 percent of Ethiopians live within a two-hour's walk to a modern health care facility. One-fifth of Ethiopian children die before they reach the age of 5, often from diarrhea, measles, respiratory infections, malaria, and other preventable diseases. Poor nutritional status and high rates of infection combined with high fertility rates (the average Ethiopian woman bears nearly seven children in her life time) contribute to one of the highest maternal mortality rates in the world, estimated at seven to 14 deaths per 1,000 live births.

The composition of the government budget recently shifted significantly in favor of primary and preventive health care and basic education. However, with only 3 percent of the central government expenditure allocated to health, the eradication and treatment of HIV/AIDS in Ethiopia will be a very difficult and daunting task.

HIV/AIDS in Ethiopia

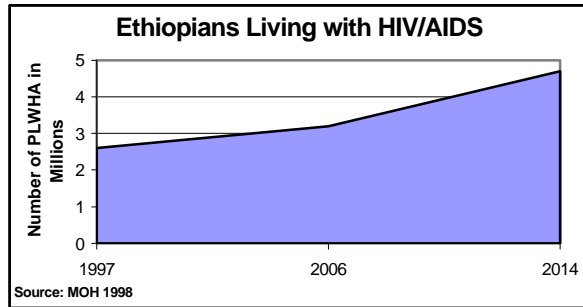
The first case of HIV/AIDS in Ethiopia was reported in 1986. The Joint United Nations AIDS Program (UNAIDS) reports that Ethiopia is one of the hardest-hit sub-Saharan African countries, with one in 13 adults infected with HIV. In urban areas, more than one in six adults (18 percent of the population) are infected.

- More than three million Ethiopians are living with HIV—1.1 million with AIDS.
- Prevalence in urban areas ranges from 18 percent in low-risk groups to 43 percent in high-risk groups. In rural areas it is 13 percent in low-risk groups.



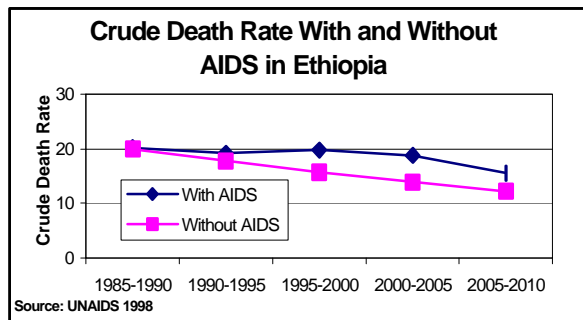
- About 90 percent of those living with HIV/AIDS are 20 to 49 years old.

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- The numbers of male and female cases are roughly equal.
- The Ministry of Health predicts that the number of people living with HIV/AIDS (PLWHA) will increase to 3.2 million by 2006, and to 4.7 million by 2014.

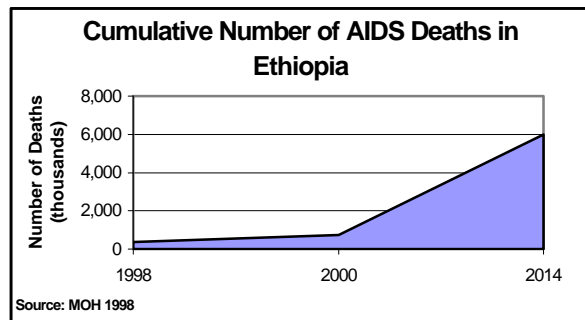
According to the Ethiopian Ministry of Health, blood transfusions, unsafe injections, perinatal transmission, and sexual contact are the four most important HIV-transmission mechanisms. Eighty-eight percent of all HIV/AIDS infections result



from heterosexual transmission and 87 percent of new HIV infections are due to the practice of multiple sex-partnering. One study of the urban population found that 22 percent of adult males and 8 percent of women engaged in sex with multiple partners.

From 1990 to 2005, AIDS will increase the crude death rate in Ethiopia by 35 percent. The cumulative number of AIDS deaths will increase from about 350,000 in 1998 to 740,000 by the year 2000, and to six million by 2014.

- 250,000 people died of AIDS-related illnesses in 1997. As a result of HIV/AIDS, average life expectancy will drop by 12 percent during the 1990s and stand at 47 years by 2025.
- AIDS will increase the death rate at all ages. However, the impact will be most severe among young adults and children under age 5. By 2014 AIDS will more than double the annual number of deaths among young adults—from 230,000 to 525,000.



Women and HIV/AIDS

The number of Ethiopian women living with HIV/AIDS is growing. Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at increased risk of HIV infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound their vulnerability.

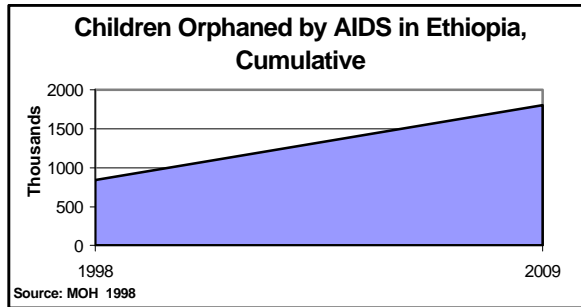
- In 1997, 18 percent of pregnant women in Addis Ababa antenatal clinics tested positive for HIV.
- The peak age group for female AIDS cases is 20 to 29 years old.
- The adult literacy rate for women is 25 percent, making it difficult to implement traditional HIV/AIDS prevention campaigns.

Children and HIV/AIDS

Forty-six percent of the Ethiopian population is under age 15. The HIV epidemic has a disproportionate impact on children, causing high

morbidity and mortality rates among infected children and orphaning many others. Approximately 30 to 40 percent of infants born to

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HIV-positive mothers will also become infected with HIV.

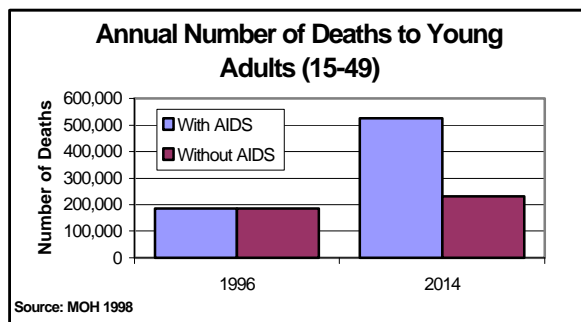
- More than 150,000 children under age 5 are living with HIV/AIDS.
- There are very few cases of AIDS among children between 5 and 14 years old.

Youth and HIV/AIDS

Youth and young adults account for a large percentage of all HIV/AIDS cases in Ethiopia. Most HIV infections occur among young people in their teens and 20s, and young women are particularly vulnerable.

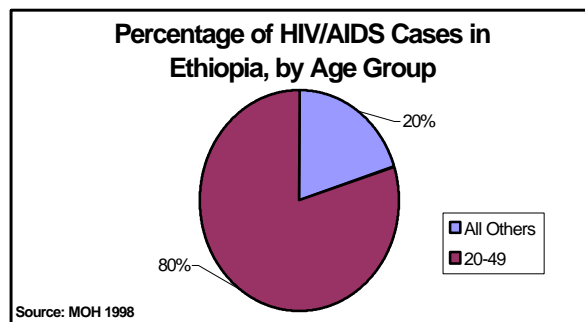
- The peak age group for new infections in Ethiopian women is 15 to 24 years old.
- The number of HIV-positive females in the 15- to 19-year-old age group is much higher than the number of HIV-positive males in the same age

- Reversing years of progress in child survival, AIDS will increase Ethiopia's infant mortality rate by 7 percent from 1995 to the year 2000.
- AIDS will soon become the major cause of death for children under age 5, overtaking other major causes such as diarrhea and respiratory diseases.
- One of the worst impacts of AIDS deaths on young adults is the increase in the number of orphans.
- To date, an estimated 840,000 children have been orphaned because of HIV/AIDS. By 2009 there will be more than 1.8 million AIDS orphans.



group. This is due to earlier initiation of sexual activity by females and the fact that their older partners often have more than one sexual partner.

- Female genital mutilation is widely practiced among Ethiopian women and girls. A 1989 study estimated that 85 percent of Ethiopian women are circumcised. This practice may lead to increased vulnerability to HIV infection.



Socioeconomic Effects of AIDS

About 90 percent of reported AIDS cases are 20 to 49 years old. Since this age group constitutes the most economically productive segment of the population, an important economic burden is created. Productivity falls and business costs rise—even in low-wage, labor-intensive industries—as a result of absenteeism, the loss of

employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development. The agricultural sector likewise feels the effects of HIV/AIDS; a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many

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cases this implies switching from export crops to food crops—thus affecting the production of cash and food crops.

There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience a reduced ability to provide for the family when forced to care for sick family members. And AIDS adversely affects children, who lose proper care

and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children and 10- to 12-year-olds become heads of households.

(For country-specific information on the socioeconomic impact of HIV/AIDS refer to the *socioeconomic analysis* presented by the Policy Project.)

Interventions

National Response

The government of Ethiopia responded to the AIDS epidemic by forming the National Task Force on the Prevention and Control of HIV/AIDS in 1985, one year before the country's first AIDS case was diagnosed. By the end of the year, the task force had issued the country's first AIDS control strategy. Ethiopia developed short- and medium-term plans in 1987, following guidelines from the Global Programme on AIDS (GPA). In September 1987 an HIV/AIDS Department was established in the Ministry of Health. The first Medium Term Plan (MTP1) focused on public awareness, establishment of laboratory services, HIV surveillance, and training of health workers.

The Second Medium Term Plan (MTP2), for the period 1992 to 1996, was designed in December 1991 based on experience gained from the implementation of MTP1. The MTP2's major intervention was to stop the spread of HIV through a multisectoral approach focusing on the decentralization of AIDS and sexually transmitted infection (STI) prevention and control activities. The AIDS Control Program employed 70 people at the national office in Addis Ababa before the

decentralization; by 1996 only three employees remained after most central department functions were shifted to regional health bureaus. An HIV/AIDS situation analysis was completed for the central and regional levels, and strategic plans were prepared for each region.

In 1998 a National Policy on HIV/AIDS, initiated in 1991, was adopted by the government. This policy attempts to broaden the government's response to HIV/AIDS and ensure full human rights protection for PLWHA. The process of passing this policy was characterized by a high degree of internal government review and a relatively low degree of participation by those outside the government. In collaboration with the Ethiopian UNAIDS Theme Group on HIV/AIDS, the National AIDS Control Program (NACP) is working toward dissemination and implementation of the National AIDS Policy and the development of the National HIV/AIDS Strategic Plan. The two bodies are also working together to strengthen the HIV/AIDS surveillance system, evaluate current HIV/AIDS prevention and control interventions, and coordinate resource mobilization.

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Donors

Multilateral and bilateral donors are actively engaged in HIV/AIDS activities in Ethiopia. It is estimated that in order to impact the country's HIV epidemic, \$10 to \$15 million per year over

the next ten years will be necessary. According to a UNAIDS/Harvard study, bilateral organization contributed the following amounts in 1996-1997 (some numbers are still not available for 1998-99):

Organization	Amount US\$ 1996-97	Amount US\$ 1998-99
The Netherlands	1,429,498	700,000 <i>(through WHO)</i>
USAID	3,900,000	1,235,310 <i>(through WHO)</i>
DANIDA	985,000	N/A
DIFID	67,500	N/A
Total	6,381,998	1,935,310

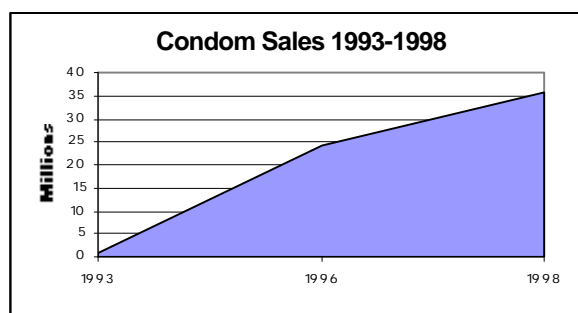
Bilateral organizations' contributions 1996-1999

USAID's HIV/AIDS funding FY 1998 was \$5.125 million. USAID is currently working with the Ethiopian government to improve a desperate health care situation. Despite the recent border conflict, USAID has committed to continuing support for HIV/AIDS activities in the country. With the passage of the government's Health Care Financing Strategy and National HIV/AIDS Policy, USAID is mobilizing to increase resources to the sector and make a concerted effort in dealing with the AIDS epidemic in Ethiopia.

The mission has supported various information, education, and communication (IEC) efforts to promote HIV/AIDS prevention, including campaigns focusing on transportation workers and passengers, and the development of integrated prevention, diagnosis, and treatment of STIs in urban areas. More specifically, 1998 activities included:

- Development of a revised AIDS Impact Model booklet
- Development of a high-level "AIDS Advocacy Luncheon" for government policy/decision makers, hosted by the U.S. ambassador.
- Implementation of an IEC program that reached over four million youths.
- Expansion of STI treatment to over 30,000 clients in urban areas.

USAID support to Population Services International has led to one of sub-Saharan Africa's most successful social marketing programs for condoms. Five years ago condoms were largely unavailable in Ethiopia. Starting in 1996, 24 million condoms were socially marketed annually, and it is estimated that over 36 million condoms were sold in 1998.



In 1999 USAID will support cooperating agencies to:

- Implement and evaluate an effective national HIV/AIDS policy, in collaboration with the NACP.
- Strengthen public and NGO capacity and participation.

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- Integrate STI/HIV/AIDS prevention and control into reproductive health programs at the national, regional, and local levels.
- Promote a nationwide Family Life Education curriculum.

USAID is also providing funding to the Ministry of Health NACP office to carry out basic programming.

UNAIDS has a coordinating Theme Group based in Ethiopia. The group, chaired by UNDP, consists of representatives from UNICEF, UNFPA, WHO, The World Bank, UNESCO, UNHCR, ECA, Ministry of Education, OAU, Ministry of Health, Ministry of Labour and Social Affairs. Support from the UNAIDS cosponsors in 1996-1999 included the following (some of the numbers for 1998-99 are still not available):

Organization	Amount US\$ 1996-97	Amount US\$ 1998-99
WHO	3,274,465	2,018,360
UNDP	260,437	N/A
UNFPA (donation of 4 million condoms for an estimated value of)	164,000	N/A
UNAIDS	350,000	350,000
UNICEF	211,460	N/A
Total	4,260,362	2,368,360

UNAIDS cosponsor support 1996-1998

In 1999 UNAIDS will assist the NACP to:

- Strengthen the country's HIV/AIDS surveillance system
- Evaluate HIV/AIDS prevention and control activities
- Formulate the National HIV/AIDS Strategic Plan
- Broadly disseminate the National AIDS Policy
- Review the HIV/AIDS prevention and control guidelines

The Norwegian government provides \$250,000 annually to the Ethiopian UNAIDS Theme Group to carry out their various activities.

Germany's Federal Ministry for Economic Cooperation and Development provided \$5.5 million for family planning and HIV prevention in 1997.

Finland's Ministry for Foreign Affairs, Department of International Development Cooperation, supported a \$5.8 million IEC project from 1995 to 1997. Implemented by the Finnish Evangelical Lutheran Mission, the project focused on developing a comprehensive AIDS information dissemination campaign, health care services, and maternity clinic and vaccination.

The Department for International Development (DFID) supported a 74,000 HIV/AIDS prevention and control program from 1995 to 1998. The campaign focused on reducing stigma by promoting the enhancement of care for PLWHA, behavior change programs, and income generating projects.

The Dutch government is currently funding a major HIV/AIDS program in Ethiopia focusing on HIV/AIDS prevention and control and the development of a vaccine.

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Private Voluntary Organizations (PVOs), Nongovernmental Organizations (NGOs) and Research Institutions

A number of PVOs implement activities funded by multilateral and bilateral donors. Some of the major USAID cooperating agencies include Family Health International, Population Services International, Pathfinder International, and The Futures Group. NGOs also receive funding from a

variety of sources and carry out most of the HIV/AIDS prevention and care activities in Ethiopia. *See attached preliminary chart for PVO, USAID cooperating agencies, and NGO target areas of HIV/AIDS activities. This list is evolving and changes periodically.*

Challenges

Major constraints to HIV/AIDS control in Ethiopia include:

- Border conflicts and other emergencies that make it difficult to make HIV/AIDS a priority.
- Lack of information about the epidemic and its consequences.
- A low literacy rate, which makes it more difficult to mount effective education campaigns.
- Poverty and a lack of resources to address HIV/AIDS and other health and development problems.
- Lack of coordination among NGOs working on HIV/AIDS.
- Underdeveloped communication networks.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in Ethiopia:

- Increased allocation of government funds to sustain the HIV/AIDS/STI prevention and control program.
- Incorporation of Family Life Education programs into school curricula in order to inform young children about HIV/AIDS.
- Behavior change interventions for at-risk groups.
- Diversified funding sources for NGOs and community-based initiatives.
- Capable and well-experienced staff for the AIDS control program, at both the national and regional governmental levels.
- Political leadership and commitment from the top.

The Future

It is not too late for an effective response to the HIV/AIDS epidemic in Ethiopia. The Ethiopian government has initiated a National Policy on HIV/AIDS and is developing a National HIV/AIDS Strategic Plan. The passage of the National HIV/AIDS Policy is an important step ahead for Ethiopia; now it is up to the country's leaders to ensure that it is implemented and

regulated, and that the National AIDS Strategic Plan is completed in a timely fashion. Experience from other countries and programs shows that strong support from top-level leaders is key to the success of the program. Ethiopia's leaders must act now to contain a rapidly growing HIV/AIDS epidemic.

Important Links

1. The National AIDS Control Program: Department of Epidemiology and AIDS, Ministry of Health, P.O. Box 1234, Addis Ababa; Tel: 15 99 88/15 98 75
2. UNAIDS Country Program Adviser: Klinton Nyamuryekung'e, UNAIDS, c/o UNDP, P.O. Box 3069, Addis Ababa; Tel: (251) 1 51 01 52; Fax: (251) 1 51 10 21; email: unaids@telecom.net.et
3. USAID: Dr. Ayana Yeneabat, P.O. Box 1014, Addis Ababa; Tel: (251) 1 51 07 16; Fax: (251) 1 51 00 43; email: Aneneabat@usaid.gov



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June 1999

Ethiopia

Organization	Intervention																
	Advoc.	BCI	Care/S	Training	Cond.	SM	Eval.	HR	IEC	MTCT	Research	Policy	STD	VCT	Orphan	TB	Other
Cooperating Agencies																	
JSI/FPLM					X												
TFGI/FPolicy Project	X											X					
FHI/IMPACT									X								
PSI						X											
Pathfinder International																	
PVOs/NGOs																	
Catholic Relief Services			X	X			X		X						X		
IPPF/WHR				X													
CARE									X								
Civil/Military Alliance to Combat HIV/AIDS	X			X				X				X					
Medical Mission Sisters	X	X	X	X				X	X	X			X	X	X	X	

KEY:	Advoc.	Advocacy	MTCT	Mother to Child Transmission activities
	BCI	Behavior Change Intervention	Research	HIV/AIDS research activities
	Care/S	Care & Support Activities	Policy	Policy monitoring or development
	Training	HIV/AIDS training programs	STD	STD services or drug distribution
	Cond.	Condom Distribution	VCT	Voluntary counseling and testing
	SM	Social Marketing	Orphan	AIDS orphan activities
	Eval.	Evaluation of several projects	TB	TB control
	HR	Human Rights activities	Other	(I.e. blood supply, etc.).
	IEC	Information, education, communication activities		